works with the general practitioner discharging them for a month, a great deal more can be done. Instead of 300 beds being used to help 300 families they can sometimes help many more families.

Finally, I would stress again, there is nothing *recherché* or obscure, nothing specially kinky about psychiatry. It is really a very straightforward subject. It requires a great deal of common sense. It requires a great deal of interrogation of one's own motives and purposes, but I think it is the most rewarding branch of medicine. After all, general medicine is so dreadfully repetitive.

REFERENCE

Barton, Russell (1966). *Psychiatric Hospital Care*. London. Baillière, Tindall and Cassell.

DISCUSSION

Dr Taylor (*Liverpool*): Would Dr Malleson comment on the general proposition that there should be no teaching hospitals?

Chairman: In this sense we have not reached the time where there should not be teaching hospitals, but when all hospitals should be used for teaching purposes. It would be good for all the hospitals to be involved in the teaching process. It would be particularly good for the consultant staffs of those hospitals to be involved. It would be good for all of us if there were not two types of consultants—for the teaching hospital and the non-teaching hospital.

Dr Malleson: I think people in my group would say that the existing pattern of formal medical school with teaching hospital leaves a great deal to be desired. One of its many faults concerns its total failure to make a relationship with the region. For the most part, it does not have regional community and district hospital care. Undoubtedly the University College Hospital characteristic is that you can almost spit at the Royal Free Hospital and the Middlesex Hospital, and there is no possibility of a hospital like this ever getting true district functions, which, to my mind, inexorably limits it for development as a modern teaching hospital, teaching the whole range of work for people who are going to work in the National Health Service as a whole. As for the actual concept of the teaching hospital, in our plan as we see it the preregistration two years are extremely important. If you really have been honest, and you must be honest if you are to pack all this into two years, and done your

clinical science course without any teaching of methodology then your preregistration job is not just a houseman on the cheap. It is a real, genuine post of which about half a man's time is in fact in supervised training. This must be worked out in relation to the medical school which qualified him. This means that in an area vastly wider than the medical school, and very often quite far-flung areas where there is no medical school, *nexi* of district hospitals must be collected together and organized in relation to a medical school to act as preregistration training centres where the output of medical schools can get their training. In this sense I would certainly agree that the training of young doctors should be disseminated among the ordinary regional hospital board hospitals.

There remains the question of the clinical course. The more you compress it the more highly organized it must be. A high degree of organization demands professors, lecture theatres, closed circuit television, a great deal of practical equipment which is very expensive, compressed into a fairly small area. Whilst I would certainly want to see such an organization in the Scottish model, i.e. in association with the regional hospital boards (we would not want to reproduce the English boards of governors ever again), I would think that some hospital in some city, be it Keele or be it Hull, or where you will, must be designated as some kind of a special hospital in which this highly organized clinical course can be organized. I do not think you can send out students on attachments to general practitioners who are not really involved in the teaching structure and know what they have got to teach. I do not think you can simply just scatter clinical students to the four winds to the regional hospitals and expect that they will pick up a consistent and integrated view of medicine in two years because they will not.

Dr Thorton (*Manchester*): In general, the pressure for hospitalization in cases of acute and chronic mental illness comes from the relatives and neighbours. This seems to me to show that psychiatry has not publicized itself well enough. After all, in the last 30 years we have managed to get rid of the fear of tuberculosis and we are now getting rid of the fear of cervical carcinoma. It does not seem to me impossible that a similar thing could be done by psychiatry. What is your view on the publicity which should be given to mental illness?

Dr Barton: I hate to throw figures at you because they say people hide behind figures. There are in the country 400,000 schizophrenics. Of that 400,000 some 50,000 are in hospital and 350,000 are outside. I am convinced that some of the 350,000 outside would be better in hospital. They would be better controlled, they would be better cared for, they would be brought under the influence of tranquillizing drugs which, say what one likes, do have an effect on schizophrenics.

Another role of the general practitioner is to ensure continued taking of drugs. Equally, of the 50,000 in hospital there are a large number who are perfectly well behaved. My two children were brought up by a parent patient with paranoid schizophrenia. I did not want to get rid of the kids, but she was just so sweet and so kind to them and they still look forward to seeing her when she comes to see us. That woman should not have been in hospital for the last 20 years, maybe she should have been in two or three years, but to be in the dump as it was, and as it is, for all that time, was I think a monstrous waste of her time in life. What we have not got is an adequate way of scrutinizing people and admitting those who ought to be in, or making sure we get those out who ought not to be in. This is all I ask for and I think if this is done there will be a much smaller mental hospital population.

Now to your second point, " What about the propaganda? " Well, of course, the public is fed with the fantasies of mental illness derived from Jane Eyre, from various films, from silly psychiatric jokes, many of which I enjoy incidentally; it bases its knowledge of what is fact on these fantasies. Remember Mrs Rochester who was locked up in the wing of the big house while her husband made love to the governess and was eventually going to marry her, and how this crazed old creature came and set fire to the place, and eventually leaped from the parapet and her brains were splattered on the flagstones. Now this sort of talk scares the pants off people. Incidentally the York Retreat was built in 1796, and it was the foremost psychiatric hospital in the world. Why wasn't Mrs Rochester in there? Of course you can defend Mrs Rochester. Take an ordinary woman locked up in the end of a house who knows her husband is having an affair with the governess. Wouldn't it be natural to try and set fire to the whole place? You don't have to involve madness. But let's get off this fiction and fantasy. The real facts of mental illness are that the majority, over 90 per cent, are meek humble people who are too preoccupied with doing the right thing sometimes, but the ten per cent who occasionally misbehave always get the headlines in the press. It is always " Headless corpse in women's hostel found, mental hospital searched " and what really happened is never subsequently revealed. I do agree with you that we need to replace the fantasies of the public by some of the facts about mental illness; people who come to a talk like this and listen, providing I have said the right things, begin to see through this nonsense that is box-office attraction, and can then say to their patients, " Yes, of course, you have a nervous breakdown but Beethoven had a nervous breakdown and so and so had a nervous breakdown ". That sort of talk does not go down with every patient because some say, " To hell with Beethoven! Who was he? " but you can put it into perspective and say, " Yes, it is un-

pleasant, it is most unfortunate, but it is not the end of the world, it is not the ultimate disaster; it is better you should have this, after all, than cancer of the brain. The majority of people recover from it, so let us have a go ". This I think replaces this phoney idea, brings more people to treatment and also helps the relatives who have to cope with them. The stigma is largely due to ignorance and the fantasy which pays the theatre, literature, television and so forth.

Chairman: Thank you Dr Barton, I am going straight home to burn my copy of Jane Eyre. I will never feel the same about it again.

Dr Pearson (*Manchester*): Can you give us any lead on measuring quality of medical care in general practice?

Dr Annis Gillie: This is one of the most difficult questions there is. On the other hand, a lot of thinking has gone into it and a certain amount of analysis, and we know that it is being undertaken not so very far away in this part of the world. Certain things can be assessed with regard to medical care. You can begin with what is revealed in the attitudes of co-operation, of critical enquiry into work as shown by the way the practitioner perhaps even speaks and produces papers evaluating his own work. There is a lot in the organization of general practice that can be assessed. I do not want to go into any more detail because I think that some of this will emerge before long in the medical press. There is no doubt that it is no good saying quality cannot be measured; some of it can be measured and once you begin measuring it, you can go on and measure more of it.

Dr Crawford (*Liverpool*): I am not disparaging the health visitor, but in view of the fact that the nursing services may be breaking down due to lack of recruits and organizations, do we feel that this is the right moment to be training health visitors who do very good work but are more of a luxury requirement, when we are short of district nurses? I myself, having had experience of the attachment of health visitors to my practice, would at the present moment equate half a district nurse to two health visitors. Has the advantage of having health visitors been more than outweighed by the loss to the nursing profession?

Miss Powell: I am not quite sure that I am qualified to answer that, because I am not a health visitor and I do not know so much about health visiting as I do about domiciliary nursing and hospital nursing. I know that many general practitioners do not somehow appreciate health visitors; one gets this feeling, but I would have thought that it needed objective evaluation. I cannot give you any answer because I do not know of any evaluation of health visitors' work, but I am quite sure that the health visitor does a very good job in preventing ill health; on the ground that prevention is better

than cure, some nurses ought to be engaged full-time in preventive work. I cannot tell you whether it would be better to employ them as nurses but I think it would be a pity to jump to the conclusion that these nurses would be better employed in curative work. All of us tend to have this attitude that we would rather be curing people than preventing illness. I think we have to be very careful about writing off health visitors. The improvement in maternal care in the maternity services must be attributed very largely to the work that health visitors did many years ago. Now whether the health visitor needs to undergo a new look and whether her efforts now need to be directed into other channels is a matter which other people might be better able to judge than I can.

Dr Johnson (*Kendal*): I wonder if Dr Malleson recognizes the fascination of the old-fashioned medical school of the 20's for the individual patient and the inspiration of the individual professor as compared with the envisaged topical teaching by the topical teachers? Will the more up-to-date methods envisaged encourage the quality of medical care dealt with by our first chairman, Dr Gillie?

Dr Malleson: It is perfectly true that certain individual consultants made very close, warm relationships with individual patients and this communicated to students to their everlasting benefit. I do not think our system of clinical groups will in any way involve that; it just means that instead of being attached to one consultant or in the course of your life three consultants (and there was a very good statistical chance that they were all stinkers), you would be attached to a group of six or seven in which there are mixed skills: surgeons, physicians, psychiatrists, paediatricians and orthopaedists and so on and their registrars. You do get an opportunity to pick up the personal relations of each one of these, including those the clinical assistant general practitioner makes with his own persons. We would say that in the end there is nothing more precious and more valuable in medicine than the personal relationship. Our criticism would be that in the modern medical school (I do not know about the 20's but certainly in the 40's) it was honoured in the breach rather than the observance. I am perfectly certain that the quality of medical care that your president can give is to some extent despite her education at medical school and not because of it.

Dr Gillie: Of course this is a matter of generation. There was a gorgeous moment when the patient whose history you were taking in a white coat, having put a stethoscope into your ears the week before, called you: " Doctor ". Just a wonderful moment. On the other hand, I am quite sure we wasted a great amount of time in the wards, especially when doing a dressing with Trotter's incredibly elaborate cases that one wasted whole mornings over. His teaching

was superb but our identification with his patients taught us very little. I would not have foregone his teaching for anything in the world, but one could have had that under topic teaching and not spent from 10 o'clock until the lunch trolleys came along at 12.00 hanging round a patient who was going to be in six months because of the pharyngectomy that he had done. I speak from one particular case and there were many of them.

Dr Lunn (*Preston*): I would like to ask about the tensions in the homes of relatives of mentally sick patients. I can speak personally from this point of view, but I found sometimes that I was treating some of the relatives more than the patients. I would like to ask what can be done for the treatment or help of the relatives of the patients? People do not realize that they do suffer from a great deal of tension.

Dr Barton: I wish we could produce a general rule that could be applied to every patient, but it is simply not possible; the only way to make sure that the maximum interests of the patient and the relatives are served is to treat each case on its merits. If one does not do this, one may leave the depressed patient at home to commit suicide; if one has a convenient rule of thumb, one may admit him to hospital where he may remain for the rest of his life. So I cannot answer your question; it depends on all the circumstances and that takes hours to work out; even then, no psychiatrist any more than any other practitioner is infallible and we make mistakes.

Dr Gatley (*Halewood*): Dr Malleson, you have envisaged a two-year preregistration period. During this period the preregistration doctor will spend about 50 per cent of his time learning practical methods. The problem is, who will carry out the vast bulk of the routine clinical work which is at present being performed by these doctors?

Dr Malleson: I think you can only do this if you greatly increase the number of medical students in training, which is one of the reasons for extending our numbers very considerably.

Dr Leech (*Warrington*) The present clinical course lasts three years; is two years long enough?

Dr Malleson: Medicine is one of those things which ideally you learn all your life. You start at school with science in your general education. You move on, as we think now, to a general period of scientific education at the university and then you learn about clinical science and how to practise it; then, we are all agreed, you must go on with postgraduate training skills. I am sure everybody in this room is agreed that you need vocational training before you do general practice, and that you do not just enter it by default. This is a life-long educative process. Now the point at which official

lines are drawn and labelled as degrees—B.Sc's, or M.B., B.S's or Registration Points—and so on are in a sense arbitary along a whole time scale. There are certain statutory requirements and they have to be drawn in, and a certain place looks as good as any to draw them, but let there be no doubt that anybody who suggests that at the end of a three-year B.Sc. Human Biology and a two-year M.B., B.S. course a person has covered his education in science and clinical science and never need think about it again, is obviously off the beam.

Dr Thomas (*Denbigh*): Does Dr Malleson agree with the idea that in the preregistration year the students are attached to a doctor affiliated to a district teaching hospital? This means that training in country practice is precluded, and it is so much easier in a city practice to send a patient down to the casualty department. General practice in the country is so very different from town practice and students should also have some knowledge and experience of this.

Dr Malleson: That is an excellent point, and I do not think either I or my group wish to make any particular recommendations about the form of any voluntary general practice phase in a preregistration period.

Chairman: I think you will agree with me that when we start to consider the quality of medical care, it is essential that we should cross-reference, that we should be trying to look at this in the large. We tend almost certainly to get the wrong answers if we try to look at the question of quality exclusively in water-tight compartments, and say to ourselves only: "What is necessary for nursing?" or "What is necessary for general practice?" or "What is necessary for psychiatry?" We really have to say to ourselves: "What are we trying to get at with our health care schemes or our medical care schemes?" "What is the objective of these schemes?" Then start back from that and think, "What is the place of quality of nursing care in this situation?" "What is the place of quality of general practice in this situation ?" and so on.

This concept of quality of care is usually brought up, as the obverse of quantity, the assumption being that we have solved the problem of quantity in this country, which may or may not be true. This concept of excellence is a very different kind of concept and there are many aspects to it. Today we have been thinking primarily in terms of excellence of professional performance and professional team-work by the doctor, especially the general practitioner, and by the nurse. We have had reviewed for us the importance of education in this promotion of excellence or quality, put so stimulatingly by Miss Powell in terms of nursing and the need particularly for leadership and for the education of leaders for nursing. We can echo Dr Malleson on the importance of community care and the

part to be played by the department of general practice in the education of the future doctor. It seems to me now essential that, just as a medical school has a hospital with a captive population for teaching and research, so too does it need a context for the study of illness and its care in the community. Therefore it needs a general practice department to be able to demonstrate health and sickness in the community. But remember that if we want general practice departments in our medical schools this development will need the backing of general practitioners in the cities where these medical schools are. It will only be with the co-operation of the profession that this kind of entity can come into existence.

I would echo also the importance of vocational training for general practice. Just as for specialism there must be a planned period of vocational education, so too there must be one for general practice. We can reflect too from the symposium we have had this afternoon that education alone has its limitations. In fact there may be dangers in educating our young people who are to serve in the health services to higher and higher specifications and expectations, if the context in which they are to work does not allow them to exercise the skills they have been taught, if the context into which they go is one of disappointment and disillusionment in terms of the expectations built up at medical school. Under these circumstances education alone is not merely limited in what it can achieve, but it may even be damaging in the sense of leading to frustration and demoralization. In a sense the context in which the education is later to be practised is even more important than the education. What is this context to be? This is the question we have to take away in our minds this afternoon. What is to be the context for practice in the community by the team of doctor and nurse? Here are these young people, educated scientifically and in terms of humanitarian and social expectations to higher and higher standards; what context of practice is needed to give them the feeling of pay-off, to give them the feeling of professional satisfaction with their work, to make them feel proud of themselves because of what they are doing professionally and for their patients? What is this context to be, compared with the context existing today, if we are to develop the kind of interaction, the kind of team work, if we are to provide the ancillary skills, if we are to provide the kind of resources for these people really to fulfil themselves professionally? This is perhaps our biggest question. The same kind of thread runs through the comments of Dr Barton in his extremely interesting address. Better standards of psychiatric preparation for the future doctor and nurse are important, but if we prepare people for these new responsibilities and allocate them to the community team, we must be honest and effective in giving them the means to ' deliver the goods '.